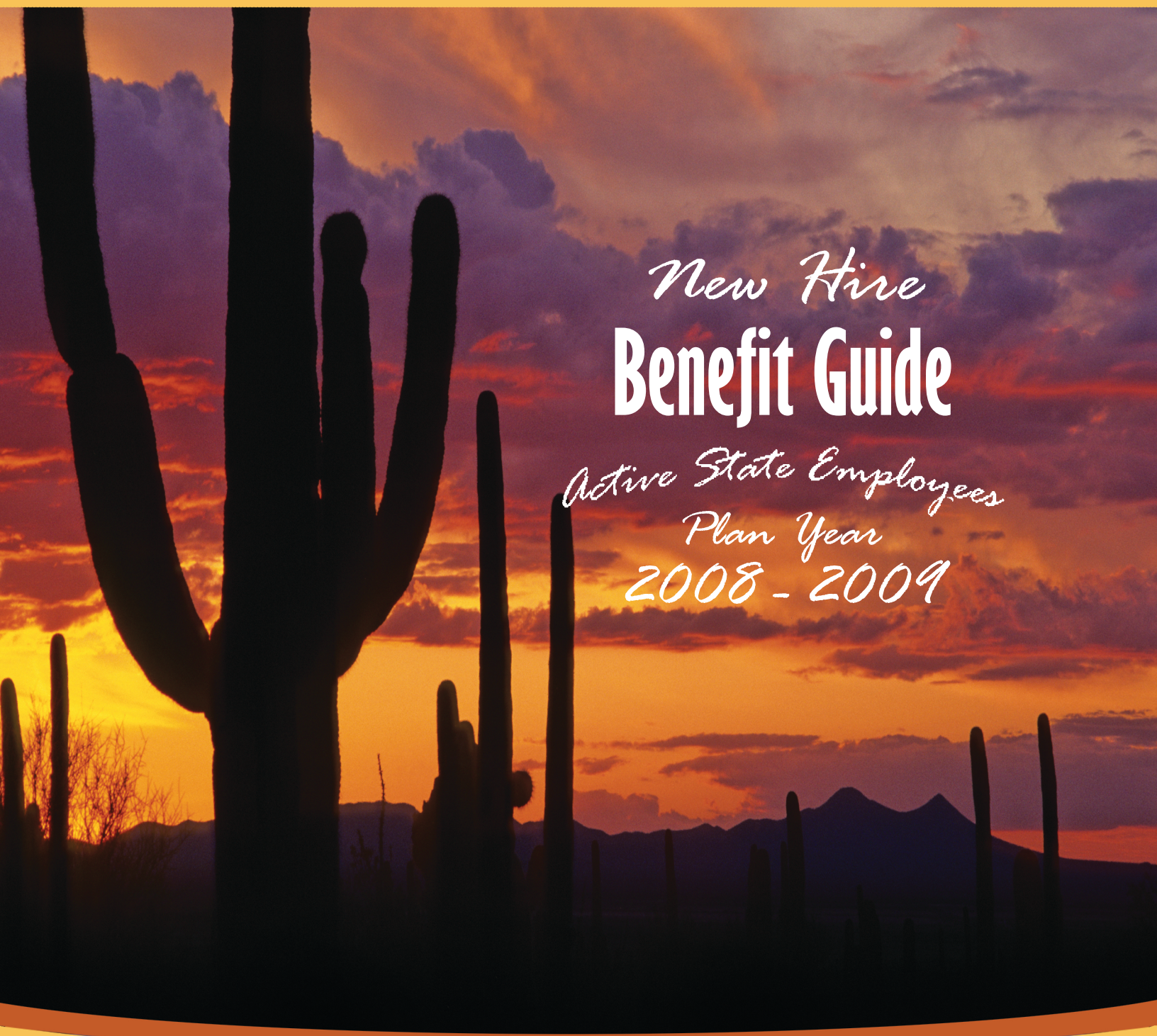
Arizona Department of Administration

Benefit Services Division



New Hire Benefit Guide

Active State Employees

Plan Year

2008 - 2009

Benefit Options

Choice. Value. Health.

Benefit Options

Wellness

Be Well Stay Well.

Table of Contents

Introduction

Benefit Options, the State of Arizona's comprehensive employee benefits package, is designed with you and your family in mind. The Employee Wellness Program is one of your most important health benefits as a State employee. We want to help you be well today and stay well for life.

The New Hire Benefit Guide is designed to provide an overview of the Benefit Options Program and the benefits other offered by the State of Arizona. The actual insurance benefits available to you and the descriptions of these benefits are governed, in all cases, by the relevant Plan Descriptions and contracts. In the event of discrepancies between this guide and relevant Plan Descriptions or contracts, including amendments, it is the contracts and plan descriptions that prevail. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefit plans at any time.

In this valuable reference guide, we included explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This document is no longer just an enrollment guide. It is a resource to use throughout the year for services and benefits provided to you as a State of Arizona employee. In this guide you will find the information you need to make informed decisions regarding the selection and continued management of your benefits.

How to Use This Guide

This guide is divided into chapters, each covering a specific benefits program or important information. These programs include:

- Employee Wellness
- Medical Plans
- Pharmacy Benefits
- Dental Plans
- Vision Plan
- Basic, Supplemental and Dependent Life Insurance
- Disability Plans
- Flexible Spending Accounts
- COBRA
- Additional Benefits

New Hires

Newly hired and returning employees must enroll for benefits coverage within 31 days of their date of hire or reinstatement. If you are nearing the end of your 31-day enrollment period and are not able to enroll using the "Your Employee Services" (Y.E.S.) website, contact your agency benefits liaison before the 31-day period has ended.

The effective date for your benefits coverage will be the first pay period following receipt of a properly executed enrollment form and required supporting documentation (provided the request is received within thirty-one (31) days of the date of hire).

Important Contact Information

Contact	Phone Number	Web Address	Policy/Group Number
Medical Plans			
UMR (formerly Fiserv Health Harrington) Arizona Foundation, Beech Street, RAN + AMN Healthcare	1.888.999.1459	www.myazhealth.com	3J
TDD/TTY	1.866.503.3463		
United Healthcare	1.800.896.1067	www.myuhc.com	705963
TDD/TTY	1.888.697.9055		
Pharmacy			
Walgreens Health Initiatives	1.866.722.2141	www.mywhi.com	512298
Dental Plans			
Delta Dental	602.588.3620 or 1.866.9state9	www.deltadentalaz.com	7777-0000
Total Dental Administrators Health Plans, Inc. (TDAHP)	602.381.4280 or 1.866.921.7687	www.totaldentaladmin.com	680100
Vision Plan			
Avesis, Inc.	1.800.828.9341	www.avesis.com	10790-1040
Flexible Spending Accounts			
ASI - Member Services	1.800.659.3035	www.asiflex.com / email: asi@asiflex.com	
Life and Short Term Disability Plans			
Standard Insurance Company	1.866.440.4846	www.standard.com/mybenefits/arizona	617950
Long Term Disability			
Sedgwick CMS (ASRS participants)	1.818.591.9444	www.vpainc.com	
Standard Insurance Company (PSPRS, EORP, CORP, OPT, RET participants)	1.866.440.4846	www.standard.com/mybenefits/arizona	
Travel Assistance			
MEDEX	1.800.633.8575	www.standard.com/mybenefits/arizona	7088
Other Important Numbers			
Benefit Options Wellness	602.771.WELL	www.benefitoptions.az.gov/wellness email: wellness@azdoa.gov	
Employee Assistance Program	602.771.9355	www.benefitoptions.az.gov/wellness/eap.asp email: wellness@azdoa.gov	
ADOA Benefit Services Division 100 N 15th Ave #103 Phoenix, AZ 85007	602.542.5008 or 1.800.304.3687	www.benefitoptions.az.gov email: beneissues@azdoa.gov	

Persons with a disability may request reasonable accommodation by contacting the Benefit Services Division.
If you need this contact information in an alternate format, please call 602.542.5008, option 2.

Employee Wellness

Being healthy one moment is one thing.
Staying healthy over the long run is yet another…

This is why one of the most important benefits for state employees is the Benefit Options Wellness Program. The Wellness Program offers state employees and retirees, and in some instances their families, health education, screenings, flu shots and more.

The State of Arizona values your health. The Wellness Program's goal is to provide services that assist employees in creating healthy lifestyles, detecting health issues early and managing existing conditions.

In the last year the Wellness Program has provided over 650 worksite classes and screenings to almost 14,000 participants.

The Wellness Program also provided 16,971 Influenza vaccinations to employees, retirees and their dependents in 2008's flu season.

The Wellness Program also sponsors the Mayo Clinic Health Assessment and EmbodyHealth Web Portal, which allows participants to become knowledgeable about their health and provides free Embody Health Coaching to help participants make healthy changes. The EmbodyHealth Web Portal (*www.bewellstaywell.az.gov*) has an abundance of tools, resources, and online programs to assist participants in becoming, and staying well.

Wellness services are available at low or no-cost and are provided by contracted professionals who will travel across Arizona providing participants with health education and screening services.

The Wellness Program offers:

- Health education classes focusing on nutrition, stress management, chronic diseases and more
- Weight Management Program – 12 weeks
- Mini-health Preventative screening (cholesterol, blood pressure, body composition, blood glucose, optional osteoporosis and prostate specific antigen).
- Mobile Onsite Mammography – mammograms at worksites across Arizona. These results are sent directly to your physician.
- Skin cancer screening
- Onsite chair massage
- Annual flu vaccine program beginning in the fall of each year

Benefit Options Wellness work-site programs are request-based programs; services are scheduled at worksites where an employee has requested them. Therefore, the Wellness Program relies on State employees to bring Wellness events to their worksites.

To learn how to request a service at your office or for additional information including a complete listing of services, visit the website *www.benefitoptions.az.gov/wellness*.

Other Wellness Services include:

- Monthly Newsletter (wellNEWS) – this electronic newsletter is sent via email to Wellness Coordinators in each agency. Each coordinator sends the newsletter to employees within that agency.
- Wellness Program Website – the website provides many online resources, the monthly newsletter, and monthly Wellness events scheduled throughout the state.
- More to come – look for more programs and services coming from the Wellness Program throughout the year by visiting *www.benefitoptions.az.gov/wellness.*

What employees are saying about the Wellness Program services:

Wellness Services – “Thank you so much for your help setting up Wellness events for our agency. The Wellness Program has given us great service and our employees are enjoying the programs that come out of your office.”

Mobile Onsite Mammography (MOM) – “If MOM hadn’t been available at work, I wouldn’t have gotten a mammogram. I don’t want to take time off work to get it done, so it’s nice I could do it right at work and it only took 15 minutes!”

Mini-Health Screening – “I was unaware that my cholesterol and blood pressure were high. This screening was a wake up call for me to see my doctor and starting living a healthier lifestyle. Thank you!”

Skin Cancer Screening – “Had it not been for the cancer screening (and my nagging yet wonderful husband), I could be in some serious trouble now and possibly facing chemotherapy. Thank you, thank you for providing this valuable service to state employees and their families. I urge anyone who even thinks they would like confirmation that the spot on his/her arm, leg or wherever, is just a mole or freckle to make an appointment and participate in the screening. It really is worth the time.”

Benefit Options Wellness is here to help you be well today and stay well for life.

ADOA
602.771.WELL (9355)
100 N. 15th Ave. Suite 103
Phoenix, AZ 85007

Benefit Options Wellness
Toll free: 800.304.3687
Email: wellness@azdoa.gov
Website: *www.benefitoptions.az.gov/wellness*

Eligibility

Active employees regularly scheduled to work 20 hours or more per week for six months or longer (except those listed below as ineligible) and their qualified dependents may participate in the Benefit Options Programs, provided they comply with the contractual requirements of their selected plans.

Ineligible Employees

A. Employees who work fewer than 20 hours per week
B. Employees in seasonal, temporary or emergency positions
C. Patients or inmates employed in State institutions
D. Non-State employee officers and enlisted personnel of the National Guard of Arizona
E. Employees in positions established for rehabilitation purposes
F. Student and work study employees

Eligible Dependents

You may add or remove the following dependents to your plans; please note that supporting documentation may be required.

A. Legal spouse
B. Domestic partner, subject to the following qualifications:
    a. Shares the employee's permanent residence;
    b. Has resided with the employee continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the employee or retiree indefinitely as evidenced by an affidavit filed at time of enrollment;
    c. Has not signed a declaration or affidavit of domestic partnership with any other person and has not had another domestic partner within the 12 months before filing an application for benefits;
    d. Does not have any other domestic partner or spouse of the same or opposite sex;
    e. Is not currently legally married to anyone or legally separated from anyone else;
    f. Is not a blood relative any closer than would prohibit marriage in Arizona;
    g. Was mentally competent to consent to contract when the domestic partnership began;
    h. Is not acting under fraud or duress in accepting benefits;
    i. Is at least 18 years of age; and
    j. Is financially interdependent with the employee in at least three of the following ways:
        i. Having a joint mortgage, joint property tax identification, or joint tenancy on a residential lease;
        ii. Holding one or more credit or bank accounts jointly, such as a checking account, in both names;
        iii. Assuming joint liabilities;
        iv. Having joint ownership of significant property, such as real estate, a vehicle, or a boat;
        v. Naming the partner as beneficiary on the employee's life insurance, under the employee's will, or employee's retirement annuities and being named by the partner as beneficiary of the partner's life insurance, under the partner's will, or the partner's retirement annuities; and
        vi. Each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney; or
        vii. Other proof of financial interdependence as approved by the Director.

Eligibility - Continued

C. Child, defined as;
    a. Natural, adopted and/or stepchild of the employee or employee's domestic partner, who is unmarried and under age 19, or under 25 if a full-time student at an accredited educational institution.
    b. Minor for whom the employee has court-ordered guardianship
    c. Foster children under the age of 19
    d. Child placed in the employee's home by court order pending adoption
    e. Natural, adopted and/or stepchild who was disabled prior to age 19
D. Older child, subject to the following qualifications:
    a. Is younger than 25,
    b. Is unmarried
    c. Was covered by a health insurance plan made available by the state during the year that the individual was 18, and
    d. Resides in Arizona, if the individual is:
        i. Is the natural child, adopted child, or stepchild of the employee, or employee's domestic partner; or is a child for whom the employee received a court-ordered guardianship when the child was 18 years old or younger

Please note: If your dependent child is approaching age 19 and is disabled, application for continuation of dependent status must be made within 31 days of the individuals 19th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, in accordance with Social Security Administration guidelines, that occurred prior to his or her19th birthday.

Dependent Documentation Requirements

If you are enrolling a spouse or dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation such as a marriage license for a spouse or a birth certificate or court order for dependents, is provided to the ADOA Benefits Office. If your dependent is a full-time student over the age of 18, your insurance carrier will request a copy of the dependent's class schedule.

Qualified Medical Child Support Order (QMCSO)

If a QMCSO exists, you must elect to continue coverage for your dependent pursuant to the order. You may not terminate coverage for a dependent covered by a QMSCO. If coverage is terminated, coverage will be reinstated retroactive to the date coverage was terminated. You will be responsible for any past due premiums, which will generally be collected through payroll deductions.

If You and Your Spouse / Domestic Partner are both State Employees

If both you and your spouse / domestic partner are benefits-eligible State of Arizona or university employees, you cannot carry coverage under your name with the State and also be covered under your spouse / domestic partner through the State. Under no circumstances may an employee elect dual coverage.

Tax Treatment of Health Coverage Provided to Older Children, Domestic Partners & Domestic Partners' Children

Medical and dental benefits are available to domestic partners, domestic partner's children and older children.

Under federal tax law, the portion of the premiums the State pays for the coverage of an individual who does not qualify as your tax dependent, as defined below, must be included in your gross income, and are therefore subject to federal income tax withholding and employment taxes (FICA and Medicare). That amount will be reported on your Form W-2. Since it is not a cash payment to you, it is considered "imputed income" and will show on your pay stub as an addition to your income for tax purposes only. For the same reason, the portion of the premium you pay that is related to the coverage of a non-tax dependent will be taken as a post-tax deduction rather than a pre-tax deduction. A domestic partner, a domestic partner's child, or older child may qualify as your tax dependent under Internal Revenue Code Section 152 (as modified by Code Section 105(b) and by IRS Notice 200479) for health coverage purposes only if the following conditions are met:

- The individual lives with you as a member of your household for the entire calendar year (this requirement applies only to a domestic partner or a domestic partner's child).
- During the calendar year you provide more than half of the individual's total support.
- The individual is not your (or anyone else's) "qualifying child" under Code Section 152(c).
- The individual is a U.S. citizen, a U.S. Resident Alien, a U.S. national, or a resident of the U.S., Canada, or Mexico. The individual could be your tax dependent even if you do not claim an exemption for him or her on your Form 1040.*

If the individual qualifies as your tax dependent, imputed income will not apply and, therefore, no taxes from imputed income will be deducted. Additionally, the portion of the premium you pay to cover the individual will be on a pre-tax basis. In order to treat an individual as a tax dependent, you must complete a Declaration of Tax Status form. The determination of whether the individual is a dependent for tax purposes is solely within your knowledge and must be determined by you. The State cannot make this determination for you. If the State does not receive a properly completed Declaration of Tax Status form from you, we will assume that your older child, domestic partner or domestic partner's child does not qualify as your tax dependent.

*For more information, consult a tax professional. Benefit Options staff cannot give out tax advice.

Other Important Information

ID Cards

ID cards for your medical, dental and vision plans will arrive separately and are sent directly from the vendor to your home address. Typically, ID cards arrive seven to fourteen business days after your benefits become effective.

- Contact the vendor directly if you do not receive your cards or if you need replacement cards.
- UnitedHealthcare, and Avesis allow members to print temporary ID cards from their websites. This may be helpful if you need services before you receive your cards.

Pre-tax Benefits

When your insurance premiums and contributions to your Flexible Spending Account(s) (see page 34) are made on a pre-tax basis, your taxable income is reduced. This means you will be paying less state, federal and Social Security (FICA) tax and, as a result, you will have more take-home pay.

Federal regulations restrict the circumstances under which you can make changes during the plan year when your monthly insurance premiums are paid on a pre-tax basis. The only time such changes can be made are:

- Annual Open Enrollment
- Qualified Life Events (see page 11)

Pre-tax deductions include:

- Medical Premiums
- Dental Premiums
- Vision Premiums
- Supplemental Life Insurance (first $35,000)
- Flexible Spending Accounts (medical and dependent care)

After-tax Benefits

Plans paid for with after-tax premiums do not have the same restrictions during the plan year. You can reduce or cancel after-tax plans without a Qualified Life Event. However, midyear enrollment can only occur in conjunction with an appropriate Qualified Life Event, provided the request is made within 31 days of the event.

Examples of plans with after-tax premiums are:

- Short-term disability
- That portion of your life insurance over $35,000
- Dependent life insurance

Changing Your Benefits

Except for plans with after-tax premiums, you may change your benefit elections during the year only when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next annual open enrollment period to make benefit changes.

Qualifying Life Events include but are not limited to:

- Changes in your marital/domestic partnership status: marriage, divorce, legal separation, annulment, dissolution of domestic partnership, death of spouse;
- Changes in dependent status: birth adoption, placement for adoption, death, or loss of dependent eligibility due to age, marriage, student status;
- Changes in employment status or work schedule that affect benefits eligibility for you or your dependents;
- Changes in residence that result in different available plan options.

Please consult with your Human Resources office to determine whether or not the life event you are experiencing qualifies under the regulations and for information regarding the effective date for the change and for the documentation required to process the change.

Timeframe to Submit a Change Request

Requested benefit changes must be submitted in writing to your agency Benefit Liaison within 31 calendar days of the event.

Effective Date of the Change

The effective date for benefit changes resulting from birth, adoption, or placement for adoption is the date of the event. The effective date for benefit changes based on all other QLEs is the first day of the pay period following the date the employee submits the requested change, in writing, to his or her agency Benefit Liaison.

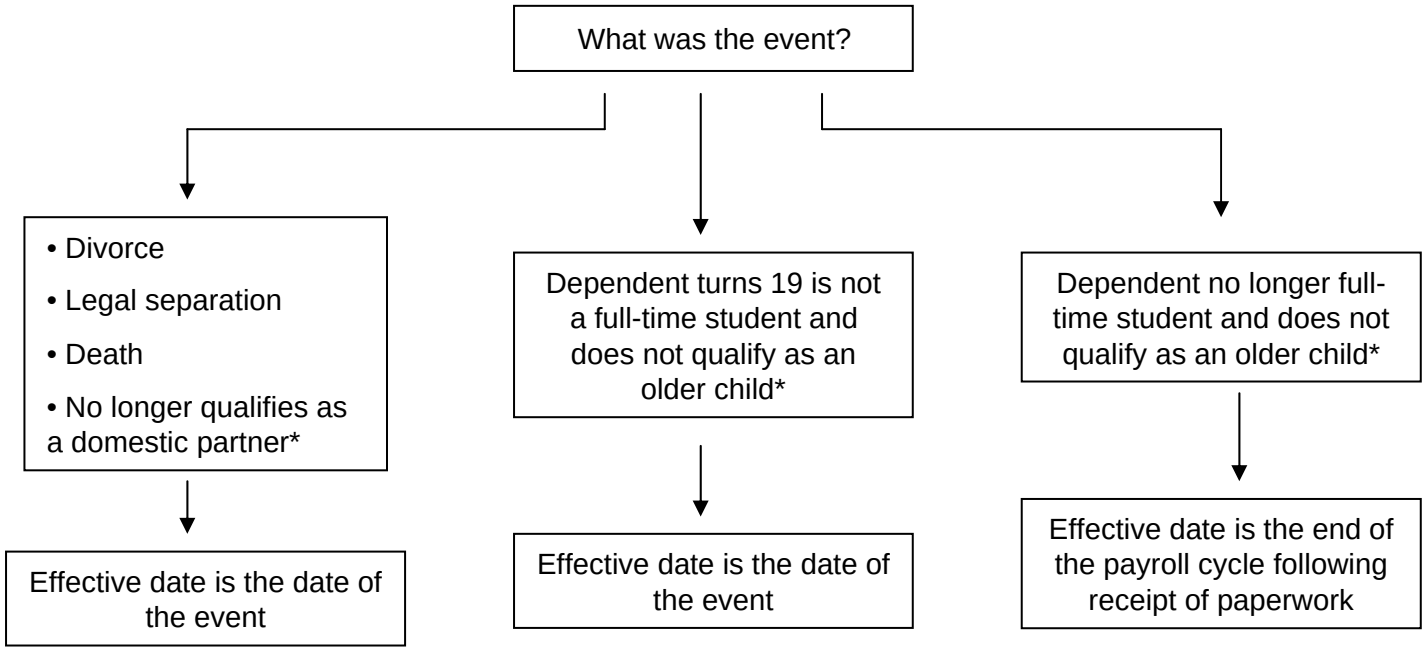
Premium Changes Due to QLEs

Any change in premiums due to a QLE will be in effect the pay period following the receipt of all QLE documentation. According to IRS regulations, no previously paid premiums will be refunded.

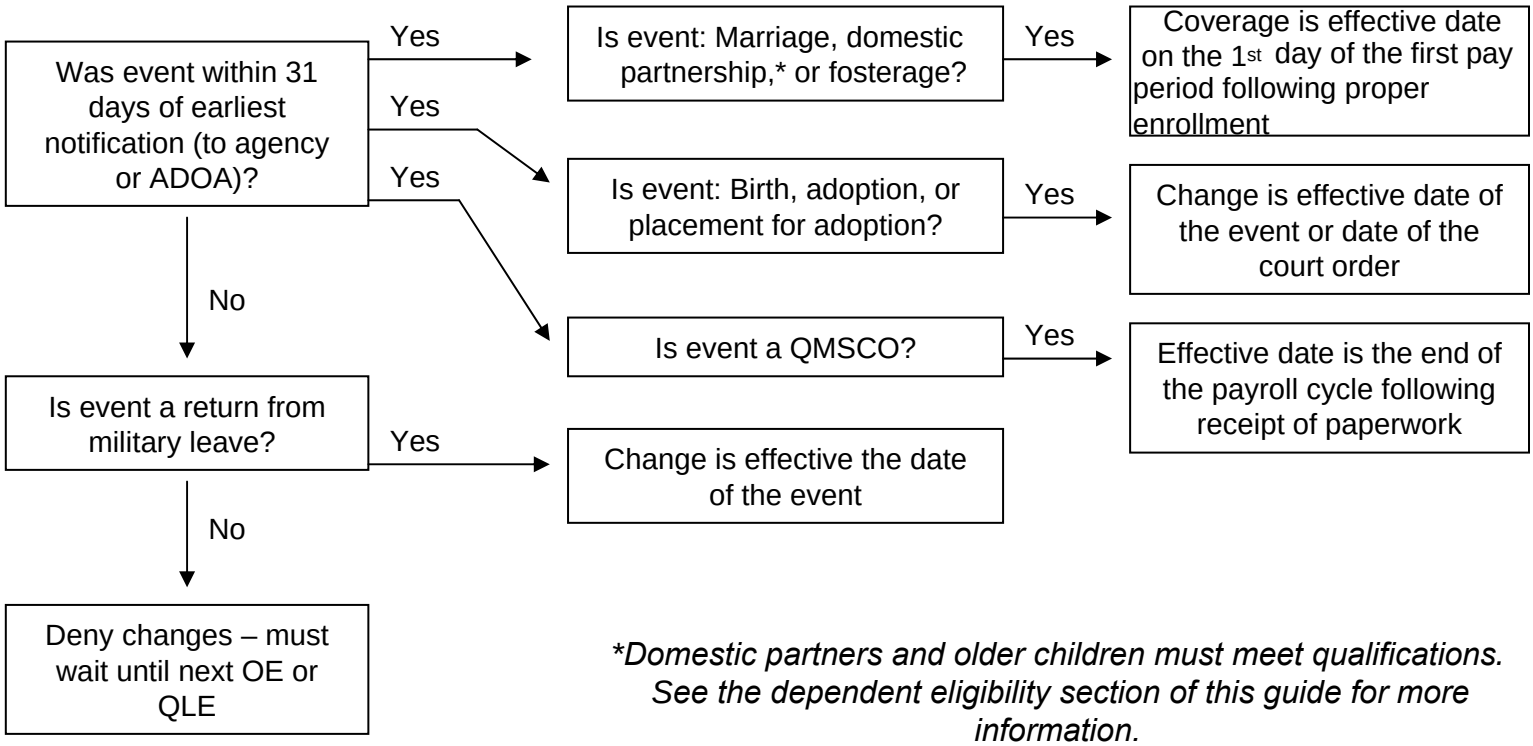
Effective Date Flow Charts

The Following flow chart will help to determine the effective dates of qualified life events.

Losing Eligibility



Gaining Eligibility



**Domestic partners and older children must meet qualifications. See the dependent eligibility section of this guide for more information.*

Premium Collection – Leave without pay

Premiums are collected through payroll deductions for those employees actively-at-work, or by personal payment for an employee on leave without pay.

Military Leave of Absence

Employees who must leave for military service are provided continued benefits through the Uniform Services Employment and Re-employment Rights Act (USERRA). USERRA provides extended health care coverage for up to (18) months. The employee may continue health coverage for a maximum of six months by paying the employee portion of premiums. After the six-month period, the employee must pay both the employee and State portions of monthly premiums until the employee returns to work or for a maximum of (18) months.

Family and Medical Leave Act (FMLA)

Employees on approved FMLA may continue health care coverage by paying the employee portion of monthly premiums.

Industrial Injury or Illness

Employees who are on leave without pay due to an industrial injury or illness may continue health coverage for a maximum of six (6) months from the date of injury or illness by paying the employee portion of premiums. After the six-month period, the employee must pay both the State and employee portions of monthly premiums until the employee returns to work or becomes eligible for Medicare or long-term disability, whichever comes first.

Non-Occupational Leave

Employees on leave without pay for a health-related reason that is not work-related may continue health care coverage for a maximum of (30) months by paying both the employee and State portions of monthly premiums until the employee returns to work or becomes eligible for Medicare or long-term disability, whichever occurs first. You may elect to change your coverage level from family to employee+one or employee only during an unpaid leave; however, you must request this change at the beginning of the leave period. If you are placed on leave-without-pay status, please check with your benefit liaison to confirm whether you have enough leave to cover your premiums or if you will need to make personal payments. Failure to pay premiums may result in cancellation of your benefits. The insurance coverage of an individual on leave without pay who fails to pay premiums when due shall terminate at 11:59 p.m. on the first day of the pay period following the pay period covered by the last premium or contribution paid.

Medical Plan FAQ

What is a Plan Administrator?

A Plan Administrator is the contracted organization that processes the medical claims, provides customer service, and runs the day-to-day operations of the health plan:

- If you enroll with the Arizona Foundation, Beech Street, or RAN+AMN healthcare, your plan administrator will be UMR (formerly Fiserv Health - Harrington Benefit Services).
- If you enroll in UnitedHealthcare, your plan administrator will be UnitedHealthcare.
- The ADOA Benefit Services Division is the Plan Sponsor - not the Plan Administrator.

I've heard the terms "integrated" and "non-integrated." What do they mean?

- Integrated and non-integrated describe the way services are provided in each health plan. If you are enrolled with Arizona Foundation, Beech Street, or RAN+AMN, you will be in the non-integrated plan. This means multiple organizations will supply the health plan services:

    1. Arizona Foundation, Beech Street, and RAN+AMN provide networks of hospitals and medical providers.
    2. UMR provides claim payments, day-to-day operations, and customer service.
    3. Strategic Health Development Corporation provides prior authorization, disease management, and medical review services.

- If you are enrolled in the integrated plan, UnitedHealthcare will provide the following: hospital and provider networks, payment processes and day-to-day operations, and prior authorization and disease management services.
- Walgreens Health Initiatives (WHI) is a Pharmacy Benefit Manager and provides pharmacy services for both the integrated and non-integrated health plans.

What is a Pharmacy Benefit Manager (PBM)?

A PBM provides the national network of pharmacies, mail-order service, and specialty pharmacy services. A PBM manages pharmacy benefits in the following ways: by providing bulk discounts on medications through the use of a formulary, by reviewing the way medications are used by members, and by implementing targeted programs to reduce overall pharmacy costs. These programs promote the use of cost-effective medications, maximize the efficiency of generic medications, and encourage proper utilization. A PBM also works with physicians to review medications prescribed and suggest lower-cost alternatives.

What is an "EPO" plan and how is this different from a "PPO" plan?

As an EPO (Exclusive Provider Organization) plan member, you must use providers who are contracted with that health plan. You must pay any co-pays as indicated. If you are enrolled in an EPO plan and use a provider who is not contracted with the plan, you will be personally liable for their bill. A PPO plan is different in that it allows in-network and out-of-network treatment. If you obtain out-of-network treatment, you will need to meet a deductible and will pay a percentage of all covered services.

The State offers “open access” in all of the EPO plans. What does this mean?

Open access refers to how you “access” physicians. Instead of getting a referral from your primary care physician (PCP) to see a specialist, you may schedule an appointment directly with a specialist of your choosing. The specialist MUST be contracted within your network. If you wish to obtain specialist referrals through your PCP, you may do that as well.

If my PCP refers me to a specialist or medical provider that is NOT within my EPO network, am I responsible for the medical charges?

Yes. In the EPO plan, all medical services must be provided by contracted medical providers. If your PCP has scheduled an appointment for x-rays, laboratory tests, or specialists, you must make sure they are within your medical network. If you are enrolled in the PPO plan, you may obtain out-of-network services by paying 30 percent of the covered charges, after you have met your deductible.

How do I find out what is covered in the health plan?

Covered benefits are described in a booklet called the Plan Description. The plan description outlines your health insurance coverage and provides information on how claims will be paid, services that require pre-certification, services that are covered and items that are excluded by the health plan. You will receive a copy of the Plan Description after the beginning of a new plan year. You may also view these descriptions online at *www.benefitoptions.az.gov*.

What is disease management?

Disease management is a service provided through an organization contracted with the State of Arizona. The purpose of the service is to assists members in managing chronic conditions. If you are being treated for any of the conditions listed below, you will be contacted by the disease management staff with further information on the program. This free service will provide you with information, assistance, and resources to manage the following conditions:

- Asthma
- Congestive Heart Failure
- Diabetes
- Coronary Artery Disease

What is perinatal care? What services are available to me if I am pregnant or planning to become pregnant?

If you become pregnant, you can receive care and education through the Benefit Options Perinatal Program. This program also helps future mothers and their newborns get a healthy start even before pregnancy begins. Resources available include:

- Preconception counseling
- Educational materials on common topics
- Screening and health assessment to help identify high risk pregnancies
- Special management of medical care by health professionals for expectant mothers with high risk pregnancies

If you become a member of Arizona Foundation, Beech Street, or RAN+AMN, you may call 1.888.999.1459 and ask for Perinatal services through the Strategic Health Development Corporation. If you are a member of UnitedHealthcare, you may call 1.800.896.1067 and ask for information on the UnitedHealthcare pregnancy services.

What is a network service area?

A network service area is the region in which your network is offered:

- The Arizona Foundation PPO plan is offered statewide.
- The Beech Street PPO plan is offered to members living outside of Arizona and will be used as a national travel network if you enroll in Arizona Foundation or RAN+AMN.
- The RAN+AMN EPO plan is offered statewide.
- The UnitedHealthcare EPO and PPO plans are offered in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties.

What is coordination of benefits?

When an employee is covered by more than one health plan or is considered a covered dependent under another plan, benefits are coordinated so that no more than 100 percent of the claim is paid to a medical provider. One plan will be considered primary and the other will be considered secondary. For additional information on how coordination of benefits will be applied, please refer to the appropriate plan description.

What is Transition of Care?

As a new employee you may continue an active course of treatment with your current health care provider and receive in-network benefits during the pre-approved transition period, if one of the following applies:

1. You have a life threatening disease or condition;
2. If you have been receiving care and the treatment is medically necessary
3. You have entered the third trimester of pregnancy on the effective date of enrollment; or
4. If you are in your second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan’s policies and procedures and quality assurance requirements.

There may be additional circumstances where continued care by a provider not participating in the network will not be available, such as when the provider loses his license to practice or retires. You may obtain a copy of the Transition of Care form at *www.benefitoptions.az.gov*.

Online Features of Medical Plan Information

Members can now review their personal profiles, view the status of medical claims, obtain general medical/pharmacy information, and learn how to manage their own healthcare through the available health plan websites.

Arizona Foundation, Beech Street, RAN+AMN

Members enrolled in any of the plans above may view the following information on *www.myazhealth.com* (member will need to register with a user name and password):

Personal Profile - Check your eligibility status and personal profile.

Claims Inquiry - View and read the status of all medical claims submitted for payment, including billed charges, any deductibles or co-pays made, the amount paid to the provider, and details on provider payments.

Deductible Status - View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.

Secure Mail - Ask questions anytime, day or night. You will receive replies about your confidential health benefit information within 3 business days without the worry of transmitting your personal information over the internet.

Health Information - Compare hospitals based on quality of care, procedures, and patient safety measures. You may also view a medical encyclopedia, information on general health topics, and an outline of questions you should ask your doctor.

Medline Plus - Medline Plus provides extensive health information on over 650 diseases and conditions, offers a medical dictionary and encyclopedia, contains information on clinical health trials, and features the latest medical research in medicine.

Provider Search - Research contracted network physicians, hospitals, and medical providers.

Provider Information - View the status of your member eligibility and all claims submitted. You can even send and receive information through the secure e-mail feature.

Claim Forms - Download claim forms and information to submit claims for medical services and reimbursement for out-of-pocket expenses.

UnitedHealthcare

If you enroll in UnitedHealthcare you can view the following information on *www.myuhc.com* (you will need to register with a user name and password):

Personal Profile - Verify benefits and eligibility. Print a temporary or order a replacement ID card anytime.

Provider Search - Find the physicians and hospitals that are convenient and right for you.

Provider Information - View the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.

Claims Inquiry - View the status of all medical claims submitted for payment, including billed charges, any deductibles or co-pays made, the amount paid to the provider, and details on provider payments.

Deductible Status - View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.

Hospital Comparison - Compare hospitals based on quality of care, procedures, and patient safety measures.

Treatment Cost - Find out and compare what different treatments will cost.

Health Information - Research a variety of health conditions, procedures, and topics. You can research a condition for yourself or on behalf of a loved one with the website's evidence-based medical information from the prestigious Healthwise and Best Treatments organizations.

Nurseline - Chat online with registered nurses seven days per week for trusted information and peace of mind when you have a question or during times when you cannot reach your doctor.

Expert Information - Participate in monthly online events with leading experts in health care.

Medical Plans Comparison Chart

	EPOs	PPOs	
These plans are available to employees statewide	RAN+AMN EPO	Arizona Foundation Medical Care PPO	
In addition to the plans above, the following plans are offered to employees in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties	UnitedHealthcare EPO	UnitedHealthcare PPO	
This plan is available to employees living out of state.		Beech Street PPO	
DEDUCTIBLE/MAXIMUMS	**In-Network Co-Pay**	**In-Network Co-Pay**	**Out-of-Network Out-of-Pocket**
PCP REQUIRED FOR EACH MEMBER?	NO	NO	NO
PCP REFERRAL REQUIRED TO SEE A SPECIALIST?	NO	NO	NO
PLAN YEAR DEDUCTIBLES INDIVIDUAL EMPLOYEE + ONE / FAMILY	$0 $0	$0 $0	$300 $600
OUT-OF-POCKET MAXIMUMS INDIVIDUAL EMPLOYEE + ONE / FAMILY	$0 $0	$1,000 $2,000	$3,000 $6,000
LIFETIME MAXIMUMS	$0	$0	$2,000,000
PHYSICIAN SERVICES Office Visits/consultations	$10 Max of 1 co-pay/day/provider	$10 Max of 1 co-pay/day/provider	30%* After Deductible
SPECIALIST VISITS	$20	$20	30%* After Deductible
PREVENTATIVE CARE Well Baby, Child and Adult Physical Exams, Annual Well-Women Exams (GYN visit & PAP smear test) Annual Well-Man Exams (Office Visit & PSA blood test), Adult Immunizations (e.g., pneumonia, flu)	$10	$10	30%* After Deductible
MAMMOGRAPHY SCREENING (Coverage based on patient age or threat)	$0	$0	30%* After Deductible
OUTPATIENT SERVICES Freestanding ambulatory facility or hospital outpatient surgical center	$0	$0	30%* After Deductible
HOSPITALIZATION SERVICES Room & Board (private room when medically necessary)	$0	$0	30%* After Deductible
Intensive Care	$0	$0	30%* After Deductible
Surgeons and Assistants, Anesthesiologists, Pathologists, Radiologist	$0	$0	30%* After Deductible
EMERGENCY CARE Urgent Center Care	$20	$20	30%* After Deductible
Emergency Room	$125, waived if admitted	$125, waived if admitted	$125, waived if admitted
Ambulance (for medical emergency or required interfacility transport)	$0	$0	Emergency paid at in-network benefit rate
CHIROPRACTIC	$10	$10	30%* After Deductible
PRE-EXISTING CONDITIONS	COVERED	COVERED	COVERED
DURABLE MEDICAL EQUIPMENT	$0	$0	30%* After Deductible
BEHAVIORAL HEALTH			
Outpatient	$10	$10	$10
Inpatient	$0	$0	30%* After Deductible

*Percentages paid based on reasonable and customary charges.
This is a summary only; please see Plan Descriptions for detailed provisions.

Pharmacy Plan Features

Is there a separate enrollment process for the pharmacy benefit?

If you elect any Benefit Options medical plan, Walgreens Health Initiatives (WHI) will be the network you use for pharmacy benefits. Enrollment is automatic when you enroll in a medical plan, and there is no separate cost.

How does the plan work?

The WHI network consists of more than 62,000 participating chain and independent pharmacies nationwide, with 1,000 pharmacies in Arizona. All prescriptions must be filled at a network pharmacy or through the mail order service. The cost of prescriptions filled out-of-network will not be reimbursed. To find a pharmacy near your home, work, vacation, or dependent student's out-of-state address, refer to *www.mywhi.com*.

Multilingual customer service representatives are available 24 hours per day, seven days per week at 1.866.722.2141 to assist you.

The WHI plan has a three-tier formulary; the cost for up to a 30-day supply of medication bought at a retail pharmacy is $10 for generic, $20 for preferred (formulary), and $40 for non-preferred (non-formulary). You can find information on WHI’s formulary and look up the cost for specific drugs at *www.mywhi.com*.

The WHI formulary is a list of medications that will allow you to maximize the value of your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are generics and brand names available at a lower co-pay than their more expensive brand-name counterparts. The pharmacy formulary is updated quarterly and as needed throughout the year to add significant new medications as they become available.

Medications that no longer offer the best therapeutic value for the plan are deleted from the formulary once a year, and a letter is sent to any member affected by the change. To see what medications are on the formulary, log on to www.mywhi.com or contact the WHI Customer Care Center to have a copy sent to you. Sharing this information with your doctor helps ensure you are getting the medications which save you money.

Encouraged use of generic medications:

Physicians have the option of approving the “generic substitution” on prescriptions. When there is a generic available and the member insists the prescription be dispensed as written (rejecting the generic), the pharmacy will ask the member to pay the difference between the generic version and the brand version of the named drug.

This policy encourages more members to choose generic drugs. If there is a medical reason for the brand name drug, the physician should not approve the “generic substitution” option. Accordingly, the member will not be charged the difference if the physician designates “no substitution;” he/she may, however, have to pay a higher co-pay.

What is the “mail order service” and how do I take advantage of it?

A convenient and less expensive mail order service is available for employees who require medications for on-going health conditions, or who will be in an area with no participating retail pharmacy for an extended period of time. Here are a few guidelines and benefits when using the mail order service:

- You must submit a written 90-day prescription from your physician for any new mail order drug.
- You may request up to a 90-day supply of medication for two co-pays.
- You may fill a 12-month supply of medication with prior authorization.
- You may pay by check or charge your co-pay to a Visa, MasterCard, American Express, or Discover account.
- You may register your email address to receive information on your orders.
- You can order refills online at www.mywhi.com or via phone at 1.866.722.2125.
- One-on-one consultations with a licensed pharmacist are also available at this number.

Clinical Prior Authorization

Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. The authorization process may be initiated by you, your local pharmacy, or your physician by calling WHI at 1.877.665.6609, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Specialty Pharmacy Program

Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Specialty Pharmacy. This program assists you with monitoring your medication needs for certain conditions and by providing patient education. The Specialty Pharmacy Program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods, special storage, handling, and delivery. Call Walgreens Specialty Pharmacy at 1.888.782.8443 for further information on this program.

The Specialty Pharmacy program includes but is not limited to the following conditions:

- Cystic Fibrosis
- Multiple Sclerosis
- Rheumatoid Arthritis
- Prostate Cancer
- Endometriosis
- Enzyme Replacement
- Precocious Puberty
- Osteoarthritis
- Viral Hepatitis
- Asthma

Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or via the mail order service.

- Anabolic steroids – injectable (Deca-Durabolin®, Virilon IM®);
- Anabolic Steroids - Oral (Anadrol-50®, Android Testred®, Oxandrin®, Winstrol®);
- Anabolic Steroids – Topical (Androderm®, Androgel®, Testoderm®);
- Botulinum Toxins (Myobloc®, Botox®);

A Specialty Care representative may contact you to facilitate your enrollment in the WHI Specialty Pharmacy Program. Trained Specialty Care pharmacy staff is available 24 hours per day, 7 days per week, to assist you. You may also enroll directly into the program by calling 1.888.782.8443.

Non-Covered Drugs

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

Online Features of Pharmacy Plan Information

Walgreens Health Initiatives (WHI)

All members enrolled in Arizona Foundation, Beech Street, RAN+AMN, and UnitedHealthcare can view the following pharmacy information by registering at *www.mywhi.com.*

Co-pay and Drug Information - Research your medication to learn what co-pay is required at a retail pharmacy or through mail-order service.

Eligibility Information - Check eligibility status for yourself and your family members.

Search the Formulary - Research medications to determine whether they are generic, preferred or non-preferred drugs. This will determine which co-pay is required.

Download the Formulary - Print a copy of the formulary to work with your medical provider on locating the right cost-effective medication for you.

Locate a Nearby Pharmacy - View pharmacies in your area by ZIP code or city.

Prescription History - You may view your entire prescription history, including all of the medications received by each member.

Mail Service Forms - Register for mail-order service by downloading the registration form and following the step-by-step instructions.

Refill Information - Review refill information, including when your next refill can be ordered and available options to request your next refill.

Drug Information - Research information on prescribed drugs to include the uses of the drug, how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.

Product News - View the latest product news including drug recalls and industry advances in the pharmaceutical industry.

How to Use Your Dental Plan

Following is a brief description of the dental plans available through Benefit Options. For a complete listing of covered services for each plan, please refer to the plan description located on the website, www.benefitoptions.az.gov. Occasionally, covered services and supplies are subject to change based on the American Dental Association Guidelines. These changes may also result in a change to your co-payment.

Available Plans to Choose From

Employees may choose between two plan types. They are the Prepaid and the Indemnity / Preferred Provider Organization (PPO) plans.

Prepaid Plan

- You must see a participating dental provider (PDP) to provide and coordinate all of your dental care
- No annual deductible or maximums
- No claim forms
- No waiting periods
- Pre-existing conditions are covered
- Set co-payments for services provided by your general dentist

Total Dental Administrators Health Plan, Inc. (TDAHP)

Each family member may choose a different general dentist. You can change your dentist by contacting TDAHP by telephone or by using the “change my dentist” function on the website *www.totaldentaladmin.com*. Fixed prosthodontic procedures (crowns and bridges) and removable prosthodontic procedures (full and partial dentures) have set lab fees. Separate lab fees apply to some services as indicated in the schedule of benefits.

Members may self-refer to dental specialists within the network. Specialty care (root canals, periodontics, oral surgery, and orthodontics) is provided at the co-payment listed in the Plan Description. Specialty services not listed are provided at a discounted rate. This discount also includes pedodontic and TMJ care.

Indemnity / PPO Plans

- You may see ANY licensed dentist anywhere in the world.
- Deductible and/or out-of-pocket payments apply.
- You have a maximum benefit of $2,000 per person per plan year for dental services.
- There is a maximum lifetime benefit of $1,500 per person for orthodontia.
- You may need to pay up-front and then submit a claim form for eligible expenses to be paid.
- Benefits may be based on reasonable and customary charges.

Delta Dental

Over 80 percent of Arizona's licensed dentists participate in the Delta Dental Plan and agree to accept Delta's allowable fee as payment in full after any deductibles and/or co-payments are met. Amounts billed by network providers in excess of the allowable fee will not be billed to the patient. If you choose to see a non-participating dentist, Delta Dental will still provide benefits, although typically at reduced levels.

Dental Plans Comparison Chart

	TDAHP Total Dental Administrators	Delta Dental
PLAN TYPE	Prepaid	Indemnity/PPO
DEDUCTIBLES	None	$50/$150
PREVENTIVE CARE	Co-Pay	Co-Insurance
Office Visit	$0	$0 Deductible Waived*
Oral Exam	$0	$0 Deductible Waived
Prophylaxis/Cleaning	$0	$0 Deductible Waived
Fluoride Treatment (to age 19)	$0	$0 Deductible Waived
X-Rays	$0	$0 Deductible Waived
BASIC RESTORATIVE		
Office Visit	$0	0
Sealants	$10/tooth	20%
Fillings	Amalgam: $10 - $37 Resin: $26 - $76	20%
Extractions	Simple: $30 Surgical: $60	20%
Periodontal Gingivectomy	$225	20%
Oral Surgery	$30 - $145	20%
MAJOR RESTORATIVE		
Office Visit	$0	0
Crowns	$270 + $185 Lab Fee ($455)	50%
Dentures	$300 + $275 Lab Fee ($575)	50%
Fixed Bridgework	$270+185 Lab Fee ($455), per unit	50%
Crown/Bridge Repair	$75	50%
Inlays	$250 - $327	50%
ORTHODONTIA		
Child	$2,800 - $3,400	50%
Adult	$3,200 - $3,700	50%
TMJ Services		
Exam, services, etc.	20% Discount	No coverage
MAXIMUM BENEFITS		
Annual combined preventive, basic, and major services	No dollar limit	$2,000/person
Orthodontia Lifetime	No dollar limit	$1,500/person

*Office visit and exams of any type are covered only two times a year at 100%.
This is a Summary only; please see Plan Descriptions for detailed provisions.

Vision Plan Features

Coverage for vision examinations and corrective eyewear is available through Avesis, Incorporated. Employees are responsible for the full premium cost of this voluntary plan for themselves and their dependents.

You may receive services from either a participating or a non-participating provider once per plan year. Exceptions are the LASIK benefit, which is available one time only and only with a participating LASIK center, and the additional eyewear benefit, which you may use as many times as you wish with a discount within a participating provider's office.

Participating Provider

To find a participating provider, either go online to *www.avesis.com* or call Avesis customer service at 1.800.828.9341. Then call the provider and identify yourself as an Avesis member employed by the State of Arizona and schedule your appointment. You can choose to receive your services from a participating optometrist, ophthalmologist or selected retail chain store.

	Co-Pay	Allowance
1) Vision examination and **one** of the following:	$10	
a) Single, bifocal, trifocal, or lenticular lenses and frame		$100 - $150 allowance
b) Contact Lens*		$130 allowance
c) LASIK Surgery		$150 allowance
2) Options (E.g. Progressive lens, tinting, coatings, transitional lens)		20% discount from provider's fee

*Contact lenses would be covered in full if considered medically necessary.

Non-participating Provider

If services are received from a non-participating provider, you will pay the provider at the time of service and submit a claim to Avesis for reimbursement. The claim must be filed within three months from the date of service and include your name, member ID number and mailing address, the patient's name and date of birth, the group name and number, and an itemized statement of services. An out-of-network reimbursement form is available by visiting the Avesis website at *www.avesis.com.*

Non-Participating Provider Fee Schedule / Amount Employee is Reimbursed			
Vision Examination	Up to $50	Frames	Up to $50
Single Vision Lenses	Up to $30	Options (e.g. tinting, coatings)	$0
Bifocal Lenses	Up to $45	Contact Lens Benefit*	see below
Trifocal Lenses	Up to $55	Elective	$150
Lenticular Lenses	Up to $110	Medically Necessary	$300
Progressive Lenses	Up to $45	LASIK Surgery	$0

*Member may choose to receive either spectacle lenses and a frame OR the contact lens benefit. The contact lens benefit takes the place of the exam, lenses and frame within that plan period.

This is a brief description of your voluntary vision care plan available through Benefit Options. For a complete listing of covered services for this plan, please refer to the Plan Description located on the website, www.benefitoptions.az.gov or contact Avesis directly at 1.800.828.9341.

Arizona, National, and International Coverage
(Medical, Dental, and Vision)

	Within Arizona	Within United States	International
MEDICAL CARE			
EPO Plans			
RAN+AMN	Covered in-network	Covered using Beech Street provider	Emergency and urgent only
UnitedHealthcare	Covered in-network	Covered using UHC EPO provider network	Emergency and urgent only
PPO Plans			
Arizona Foundation	Covered in/out-network	Covered using AZF PPO in/out-network or Beech Street provider	Emergency and urgent *
Beech Street	Covered in/out-network	Covered in/out-network	Emergency and urgent *
UnitedHealthcare	Covered in/out-network	Covered using the UHC PPO in/out provider network	Emergency and urgent *
NAU Only			
Blue Cross Blue Shield PPO		Outside AZ: Covered as in-network only if you receive covered services from a provider who participates as a PPO provider with the local BCBS plan. For assistance in locating a local BCBS network provider in another state, call 1.800.810.2583.	For assistance with locating a provider and submitting claims, call1.800.810.2583 or 1.804.673.1686. For an international claim form, go to www.bcbs.com/bluecardworld wide/index.html
PHARMACY			
Walgreens Health Initiatives	Covered in-network	Covered in-network	Not Covered
DENTAL CARE			
Prepaid Plan			
Total Dental Administrators Health Plan, Inc.	Covered in-network	Emergency Only	Emergency Only
PPO Plan			
Delta Dental	Covered in/out-network	Benefits are covered as in-network through participating providers and non-network under non-participating provider benefits.	Coverage is available under non-participating provider benefits.
VISION CARE			
Avesis	Covered in-network	Covered using in-network providers. You may call 1.800.828.9341 to locate a vision provider in the area in which you are traveling.	Covered as out-of-network and will be reimbursed based on the Avesis reimbursement schedule

Note: Coverage will be subject to the Plan Description *Any other services would be covered at an out of network level.

National and International Travel Assistance

MEDEX Travel Assist provides pre-trip assistance, medical assistance, personal security services, and emergency medical/transportation services throughout the United States and abroad.

Who Is Covered

All state employees and eligible dependents are able to use this service.

Pre-Trip Assistance

You can contact the MEDEX Travel Assistance Center at 1.800.527.0218 to receive important information before you leave or while you are en route:

- Consulate and embassy locations
- Currency exchange information
- Health hazards advice and inoculation requirements
- Passport and visa information
- Weather information
- Hotel and airport locator service

Medical Assistance

If you are outside of Arizona and more than 100 miles from your residence for a maximum of 90 days, MEDEX will assist you with:

- Locating medical care
- Communicating with medical providers
- Language translation
- Hotel convalescence arrangements
- Weather information
- Medical insurance coordination for medical care
- Obtaining prescription drugs

Emergency Transportation Services

Transportation services are arranged and covered up to a combined single limit of $150,000. Related medical services, medical supplies, and a medical escort are covered when applicable and necessary. The following are also included:

- Repatriation if it is medically necessary after initial treatment and stabilization
- Family or friend travel arrangements if you are hospitalized for more than 7 days and are traveling alone. MEDEX will provide round-trip economy airfare for one family member or friend to the location of your hospital
- Return of dependent children if you are hospitalized for more than 7 days. To coordinate the return of a dependent back to the United States, MEDEX will provide one-way economy airfare for children under age 18 to their permanent residence, including an escort, if necessary
- Vehicle return if you require emergency evacuation or repatriation

Travel Assistance Services

MEDEX provides a variety of travel and technical assistance:

- Emergency credit card and ticket replacement for lost, stolen, or damaged cards or tickets
- Emergency passport and document replacement for lost, stolen, or damaged passports or travel documentation
- Emergency cash and payment assistance care
- Emergency message service to relay information to family members
- Missing luggage assistance
- Location of legal assistance
- Bail bond services

Personal Security Services

MEDEX provides real-time security intelligence in the event you feel you are threatened due to political unrest, social instability, weather conditions, health or environmental hazards. In the event of a threatening situation, MEDEX assists you in making evacuation and logistical arrangements such as ground transportation and housing. MEDEX can also assist in making arrangements with providers of specialized security services.

MEDEX Does Not Cover:

- Involvement in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, insurrection, military or usurped power
- Traveling against the advice of a physician
- Traveling for the purpose of obtaining medical services or treatment
- The commission of, or attempt to commit, an unlawful act
- Injury or illness caused by or contributed to by use of drugs or intoxicants, unless prescribed by a physician
- Psychiatric, psychological or emotional disorders, unless hospitalized
- Pregnancy and childbirth, except for complications of pregnancy
- Participation as a professional in athletics
- Expenses incurred for emergency evacuation or repatriation services as a result of injury or sickness while traveling within 100 miles of your place of residence
- Traveling outside your home country for more than 90 days in any one trip.

How to Access Services

You may call 1.800.527.0218 and request a travel assist ID Card. The Group Number for the State of Arizona is 7088.

Life Insurance Benefits

Basic Life Insurance and AD&D

You are automatically covered for $15,000 of basic life insurance provided through Standard Insurance Company at no cost to you. The State also pays for an additional $15,000 of Accidental Death and Dismemberment (AD&D) insurance coverage. A $15,000 Seat Belt Benefit may also be payable if you die in an automobile accident and are wearing a seat belt. You are automatically enrolled in these three programs. No enrollment is necessary.

Supplemental Life Insurance and AD&D

Supplemental life insurance coverage is available to employees who would like additional life insurance beyond what the State provides. Your cost is based on your age as of October 1st (the first day of the plan year). The maximum amount of supplemental life insurance that you can elect through the State’s group plan is three times your annual base salary, or $300,000, whichever is less. Your employee supplemental AD&D coverage is the same as the supplemental life amount that you elect.

When electing or changing supplemental life after your initial enrollment, you may increase or decrease your supplemental life coverage. You may increase in multiples of $5,000 up to a maximum $20,000 per year. You may also decrease your coverage in multiples of $5,000 or cancel your coverage. Supplemental life coverage above $35,000 is paid on an after-tax basis, and may be cancelled at any time.

In the event of your death, employee life and AD&D benefits are paid to your designated beneficiary. It is important to keep your beneficiary information current. You may change your beneficiary using the web enrollment system during Open Enrollment. Remember: Adding a beneficiary does not automatically delete a previously-designated beneficiary. If you wish to change a previously designated beneficiary, you must actively do so while enrolling via the website.

Dependent Life Insurance

You may purchase life insurance coverage for your spouse and/or dependents in the amount of $2,000, $4,000, $6,000, $12,000, or $15,000. You do not have to elect any standard supplemental coverage from The Standard for yourself in order to choose this dependent plan. Each person will be covered for the amount you choose for a small monthly premium. In the event of a claim, you are automatically the beneficiary.

Short-Term Disability (STD) Insurance

If you elect Short-Term Disability (STD) insurance and Standard Insurance Company determines that based on medical opinion, you are unable to work due to illness, pregnancy, or a non-work-related injury, you may receive a weekly benefit for up to 26 weeks. The amount of the STD benefit will equal up to 66-2/3% of your predisability income. The weekly minimum benefit is $57.69; the weekly maximum Benefit is $769.27. There are no pre-existing condition limitations. You must meet the actively-at-work provision. Coverage becomes effective on the pay period start date following the agency's receipt of completed forms or successful Y.E.S. enrollment. Benefits become payable on the first day of disability due to an accident or the 31st day of disability due to illness or pregnancy, if coverage was elected during your initial new hire or eligibility enrollment period.

If you previously waived STD coverage and enroll during Open Enrollment or due to a Qualified Life Event, your insurance becomes effective as follows:

- On the following October 1 if you enrolly during Open Enrollment.
- On the first day of the pay period following agency receipt of completed qualified life-event forms. Note: changes must be submitted in writing within 31 calendar days of the event.

If you become disabled during the first 12 months of coverage, your benefits will become payable on the 61st day of disability due to illness or pregnancy.

The Standard STD plan includes a Return-to-Work incentive provision. See plan information for details on this program.

Long-Term Disability (LTD) Insurance

As a benefits-eligible employee, you are automatically enrolled in one of the State's two Long-Term Disability (LTD) programs, starting with your first day of work (participation is mandatory). The retirement system to which you contribute determines the LTD program available to you. Refer to the list below for the name of your LTD program:

Arizona State Retirement System (ASRS): Sedgwick, CMS (formerly VPA, Inc.)
(Administered through ASRS)

Your LTD benefit will pay up to 66-2/3% of your monthly income during your disability as determined by Sedgwick, CMS and based on supporting medical documentation. Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other disability benefits. LTD benefits can be paid until age 65 or until you are able to return to work after your disability as determined by Sedgwick, CMS. Medical documentation of your disability is required to continue your payment of benefits. You may learn more about the LTD plan offered by ASRS by visiting: www.azasrs.gov or calling 602.240.2000 or 1.800.621.3778, if outside of Phoenix. For hearing impaired, please contact TTY 602.240.5333.

Public Safety Personnel Retirement System (PSPRS), Corrections Officer Retirement Plan (CORP), Elected Officials' Retirement Plan (EORP), Optional Retirement Plans of the Universities (TIAA-CREF, VALC, and Fidelity Investments) Standard Insurance Company is administered through ADOA. The amount of the LTD Benefit will equal up to 66-2/3% of your base monthly pre-disability earnings. Disability will be determined by The Standard based on supporting medical documentation.

Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other disability benefits.

LTD benefits can be paid until age 65 or until you are able to return to work after your disability as determined by The Standard. Medical documentation of your disability is required to continue your payment of benefits. You may learn more about the LTD plan offered by The Standard by visiting: *www.standard.com* or calling 1.800.447.3146.

If you are facing a possible long-term disability, you should contact your agency benefit liaison or human resources office within 60 to 90 days from the date of your illness or injury for the information you need to apply for LTD benefits. This could include a waiver of insurance premiums (while collecting LTD, the LTD carrier may waive your life insurance premiums) or life insurance conversion (converting your supplemental policy from a group policy to an individual one). Although your life and/or disability insurance premiums may be waived, your medical, dental and vision insurance premiums are not waived. You are still responsible for payment of these premiums.

Flexible Spending Accounts

You have the option to participate in the medical and/or dependent care (child or elder care) flexible spending accounts (FSA) administered by ASI. These accounts allow you to reduce your taxable wages and to save taxes. Please note:

- You must enroll every year – your elections do not carry over to the new plan year.
- You specify the annual dollar amount of your earnings to be deposited to each account. This annual amount is deducted in 26 equal payments, one each pay period.
- The amount is deducted from your check before taxes are taken out, lowering your taxable income and possibly lowering your tax liability.
- After you incur an eligible expense, you submit a claim form and copies of your invoices to ASI for reimbursement. To ensure that you will be reimbursed for a given expense, you are encouraged to verify the eligibility of the expense on the ASI website, *www.asiflex.com,* before incurring the expense.
- ASI reimburses you from the money you have set aside in your FSA. ASI processes claims for reimbursement on a daily basis.
- ASI offers direct deposit for your reimbursement and email notification of your reimbursement. Complete the application for direct deposit on the ASI website, www.*asiflex.com*.

Remember: dependent care is for child care and elder care. Dependent medical expense would be reimbursed from the medical, not dependent care, FSA.

It is important to set aside only as much money in your FSA as you intend to use each plan year. Beginning in October 2008, the eligible time to utilize services for claims reimbursement for medical account only has been extended to 2 and ½ months after the plan year ends. This means you have from October 1, 2008, through December 15, 2009, to utilize services for the plan year beginning on October 1, 2008. All claims for medical expenditures must be filed with ASI prior to the last day of January following the close of the reimbursement period, January 31, 2010, for the plan year beginning October 1, 2008.

Dependent care services must be utilized in the applicable plan year. For example, child care services must be incurred (provided) between October 1, 2008, and September 30, 2009, for the plan year starting October 1, 2008. Claims for dependent care must be filed with ASI no later than midnight on December 31, 2009, for the plan year beginning October 1, 2008.

Any monies not claimed by the employee within the specified time period allowed will be forfeited in accordance with Internal Revenue Service regulations.

Upon Employment Termination

Once your employment is terminated:

- You may continue to submit claims for expenses incurred through your termination date but not incurred after your termination date.
- You forfeit any remaining monies unless you elect to continue FSA contributions through COBRA until the end of the plan year.

If you elect to continue FSA through COBRA, your contributions will be post-tax and the amount will be calculated as follows:

An additional 2% per pay period for the remaining number of pay periods will be charged in addition to the original pay period amount for administration of FSA under COBRA.

In order to assist you in calculating expenses for medical and/or dependent care, a form has been provided at *www.benefitoptions.az.gov* under the flexible spending account link.

Flexible Spending Accounts (FSA) Worksheet

Deciding How Much to Deposit

Calculate the amount you expect to pay during the plan year and calendar years for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed the established IRS calendar year or your employer's plan year limits (Medical limit = $5,000; Dependent Care limit = $5,000). Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you.

TAX-FREE MEDICAL EXPENSE WORKSHEET	TAX-FREE DEPENDENT CARE WORKSHEET
Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is October 1, 2008 through December 15, 2009	Estimate your eligible dependent expenses for the plan year, which is October 1, 2008 through September 30, 2009
YOUR AND YOUR DEPENDENTS UNINSURED MEDICAL, DENTAL AND VISION EXPENSES $_____ $_____ $_____ $_____ $_____ $_____	**NUMBER OF WEEKS** you will have dependent (child, adult or elder) care expenses from October 1 through September 30. *Remember to subtract holidays, vacations, and other times you may not be paying for eligible child, adult, or elder care.* **Weeks _____**
SUBTOTAL Estimated eligible uninsured medical expenses for your family's period of coverage during the year cannot exceed $5,000 $_____	**MULTIPLY** by the amount of money you expect to spend each week $_____ **SUBTOTAL** Remember, your total contribution cannot exceed $5000. $_____
DIVIDE by the number of paychecks you will receive during the plan year*. **This is your pay period contribution*= $_____**	**DIVIDE** by the number of paychecks you will receive during the plan year*. **This is your pay period contribution*= $_____**
* If you are a new employee enrolling after the plan year has started, divide by the number of pay periods remaining in the plan year.	* If you are a new employee enrolling after the plan year has started, divide by the number of pay periods remaining in the plan year.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit. To obtain an application, visit the ASI website at *www.asiflex*.com.

Medical and Dependent Care Flexible Spending Accounts

	MEDICAL CARE	DEPENDENT CARE
Maximum Contributions	$5,000 annually	$5,000 annually ($2,500 if married and filing separately)
Minimum Contributions	$130 annually	$260 annually
Use of the Account	* To pay (with pretax money) for health-related expenses that are not covered or only partially covered by your health plans, including expenses for your spouse or children not enrolled in your medical, dental, or vision plans. * To pay for over-the-counter medications that will be used to treat an existing or imminent condition	* Expenses for care of an eligible dependent that is provided inside or outside your home. * Care provided for your children under the age of 13 for whom you have custody, for a physically or mentally handicapped spouse or other dependents who spend at least eight hours a day in your home * Dependent care provided so that you can work
Samples of Eligible Expenses	* Copayments * Deductibles * Charges above reasonable and customary limits * Dental fees * Eyeglasses, exam fees, contact lenses and solution, Lasik surgery * Orthodontia * Nonprescription medications (e.g., cold medicines, allergy medicines, antacids, pain relievers)	* Services provided by a day care facility. Must be licensed if the facility cares for six or more children * Babysitting services while you work * Practical nursing care * Preschool
What is Not Covered	* Premiums for medical or dental plans * Items not eligible for health care tax exemptions by IRS (e.g., cosmetic surgery) * Long-term care expenses	* Private school tuition including kindergarten * Overnight camp expense * Babysitting when you are not working * Transportation and other separately billed charges * Residential nursing home care
Restrictions/Other Information	* See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's web site at *www.asiflex.com* for specific details on what expenses are allowed * You cannot transfer money from one account to the other * Your election amount may be increased (but not decreased) if you have a Qualified Life Event	* See IRS Publication 503 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's web site at *www.asiflex.com* for specific details on what expenses are allowed * You may not use the account to pay your spouse, your child who is under age 19 or a person whom you could claim as a dependent for tax purposes * You cannot change your election unless you have a Qualified Life Event

Flexible Spending/Qualified Life Events/Mid-Year Changes
You cannot change your elections to your Medical or Dependent Care FSA elections after Open Enrollment unless you have a Qualified Life Event as defined by the IRS that causes you, your spouse or a dependent to gain or lose coverage. The requested change must correspond with the gain or loss of coverage and must be submitted in writing within 31 days of the change.

If you have a Qualified Life Event:

- You may increase the amount in one of the accounts or both
- Midyear reductions to the Medical and Dependent Care FSA are not permitted.

Tax Credit

There are additional IRS rules that apply to your Dependent Care FSA contributions. You may be eligible to claim the dependent care tax credit on your federal income tax return. You may want to consult a tax advisor to determine whether participating in the Dependent Care FSA or taking the dependent care tax credit gives you the greater advantage.

Using Your Flexible Spending Accounts

You have several options for obtaining and filing a claim against your Flexible Spending Account. You may obtain a claim form in the following ways:

- You will be sent an initial packet containing claim forms. These may be copied.
- On the web - You may download a claim form at www.asiflex.com.
- On the phone - You may call ASI at 1.800.659.3035 and request a claim form.
- By mail - You may request a claim form by sending a written request to: ASI, P.O. Box 6044, Columbia, MO 65205.

You will need to fill out your claim form and attach copies of invoices for services you received. Fax your claim and documentation, toll-free, to ASI or mail the claim form to the address shown above and wait to receive your reimbursement by direct deposit or check. If you wish to start direct deposit of your reimbursements after the Open Enrollment period, you will need to do so through ASI. The direct deposit request form is available at www.asiflex.com. You may also have your statements sent to you by email. Go to www.asiflex.com and follow the links to sign up. See your agency benefit liaison if you have questions or problems obtaining or submitting a claim.

COBRA Continuation of Coverage Notice

Federal law requires that most group health plans give employees and their families the opportunity to continue their group health coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan and the covered employee’s spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children, and alternative recipients under Qualified Medical Child Support Orders QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage as the State of Arizona group health insurance plan. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and HIPAA special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to group health coverage offered by the State of Arizona (the “State”) under the Plan (i.e., medical, dental, vision and health care Flexible Spending Account {FSA}) and not to any other benefits offered by the State (such as life insurance, disability, or Accidental Death and Dismemberment). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA’s requirements.

How can you elect COBRA coverage?

To elect COBRA coverage, you must complete the election form and mail or deliver the completed form by the date specified. Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the employee’s spouse may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The employee or the employee’s spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries.

You may elect COBRA under the group health coverage (medical, dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary’s COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Electing COBRA under the Health Care Flexible Spending Accounts (FSA)

COBRA coverage under the health care FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the health care FSA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for health care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage for the health care FSA, if elected, will consist of the health care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan year, and COBRA FSA coverage will terminate at the end of the plan year. All qualified beneficiaries who were covered under the health care FSA will be covered together for health care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate health care FSA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact the ADOA Benefits Office (see “For More Information” section page 45).

Special Considerations in deciding whether to elect COBRA

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA coverage may eliminate this gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage under the Plan ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

How long will COBRA coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours.

In the case of a loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months.

Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the plan year in which the qualifying event occurred and cannot be extended for any reason.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries.

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time
- a qualified beneficiary becomes covered after electing COBRA coverage under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied)
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage
- the State ceases to provide any group health plan for its employees, or
- during a disability extension period (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled

COBRA coverage may also be terminated for any reason (for example, the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage as in a case of fraud). You must notify the applicable carrier(s) (see "For More Information" section on page 45) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any applicable preexisting condition exclusion). The plan may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

How can you extend the length of COBRA coverage?

If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the applicable carriers in writing of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will affect the right to extend the period of COBRA coverage. The period of COBRA care FSA cannot be extended beyond the end of the current Plan year under any circumstances.

Disability

If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage and must last until the end of the 18-month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the applicable carrier(s) (see "For More Information" section on page 45) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours.

You must also provide this notice within the original 18 months of COBRA coverage in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to the ADOA Benefits Office (see "For More Information" section page 45).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the applicable carrier(s) of that fact within 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to spouses, domestic partners and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such events may include the death of a covered employee, divorce, legal separation or dissolution of domestic partnership from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

An extension due to a second qualifying event is available only if you notify the applicable carrier(s) (see "For More Information" section page 44) in writing of the second qualifying event within 60 days after the date of the second qualifying event.

The notice must include the following information:

- Name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event
- Nature of the second qualifying event
- Date of the second qualifying event
- Signature, name and contact information of the individual sending the notice

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the ADOA Benefits office requests it. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice within the required time periods to the ADOA Benefits Office at the addresses indicated below (see "For More Information" section page 45).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

How much does COBRA coverage cost?

Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay will not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for the same coverage.

When (and how) must the first payment for COBRA coverage be made?

If you elect COBRA coverage, you do not have to send any payment with the election form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date the election form is post-marked, if mailed, or the date your election form must be is received by the individual at the address specified for delivery on the election form, if hand delivered).

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the ADOA Benefits Office to confirm the correct amount of your first payment.

Monthly payments for COBRA coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary is shown in this notice. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Plan will send periodic notices of payments due for these coverage periods (that is, you will receive a bill for your COBRA coverage) – it is your responsibility to pay your COBRA premiums on time.

Neither ADOA nor your vendor will be able to confirm that you are entitled to services until the vendor has received your premium for the month in which the care is to be provided.

Grace periods for monthly payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

All COBRA premiums must be paid by check or money order. Your first payment for COBRA coverage should be sent to the following:

ADOA Benefits Office 100 N. 15th Ave., Ste. 103 Phoenix, AZ 85007

Note: Although initial payment is mailed to ADOA, subsequent payments must be made payable to the applicable insurer for which you are electing coverage.

Checks should be made payable to:

- UnitedHealthcare for any of the UHC plans
- UMR - Harrington Benefit Services for any of the following plans: Arizona Foundation, Beech Street, RAN+AMN
- Delta or Total Dental Administrators for dental plans
- Avesis Vision for vision
- ADOA/HITF for flexible spending premiums

After the initial payment, your monthly payments will be sent to the individual administrator/carrier. You will receive an invoice each month that will include the correct mailing address.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received. Payments made after the grace period will not be accepted. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More information about individuals who may be qualified beneficiaries

Children born to or placed for adoption with a participant during COBRA coverage period

A child born to, adopted by, or placed for adoption with a participant during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the participant has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

Alternative recipients under QMCSOs

A child of the participant who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the State during the participant's period of employment with the State is entitled to the same rights to elect COBRA as any other eligible dependent child of the participant.

For more information

This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from the ADOA Benefits Office.

If you have any questions concerning the information in this notice or your rights to COBRA coverage, you should contact the following:

ADOA Benefits Office
100 N. 15th Ave., Suite 103
Phoenix, AZ 85007
602.542.5008 or 800.304.3687

Information about COBRA provisions for governmental employees is available from:

Centers for Medicare & Medicaid Services (CMS)
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16 Baltimore, Maryland 21244-1850

Or you may call 1.410.786.1565 for assistance. This is not a toll-free number. The CMS website is *www.cms.hhs.gov.*

Keep your plan informed of address changes

In order to protect you and your family's rights, it is important that you keep the ADOA Benefits Office and the applicable health plan administrator(s) informed of any changes in your address and the addresses of family members. You should also keep for your records, a copy of any notices you send to the ADOA Benefits Office and or the applicable health plan administrator(s).

Additional Benefits

The State of Arizona offers many benefits to its employees. Here is information on other benefits for state employees.

Note: Arizona Department of Public Safety employees shall refer to the Law Enforcement Merit System Council (LEMSC) rules for leave policies and rules.

Work-Life Programs

Information on all of the supportive programs the State offers is available on the Work-Life website*: www.hr.state.az.us/worklife/.* Work-Life staff answer questions about state programs and also research additional options to help us lead more successful and effective lives.

Group Auto and Home Insurance

Employees can receive special rates on insurance through the State's Group Auto and Home Insurance Program. This program features convenient payment options, including payroll deduction. No-obligation quotes are available through Travelers, Liberty Mutual, and MetLife auto and home. Program information is available through the Work-Life website: *www.hr.state.az.us/worklife/.*

Computer Purchase Program
Employees can select a new competitively-priced computer through the external program vendor and pay for it through payroll deduction. All computer packages include a 3-year manufacturer's limited warranty and are shipped directly to the employee's home. Program information is available through the Work-Life website: *www.hr.state.az.us/worklife/.*

Employee Discount Program

All State employees, with the exception of temporary employees, interns, and board members, receive a discount card that they can register and use to gain access to thousands of local and national discounts. Program information is available through the Work-Life website: *www.hr.state.az.us/worklife/.*

Employee Suggestion Program

The Employee Suggestion Program offers both monetary and non-monetary recognition for original ideas on ways government services can be provided more efficiently or at the lowest possible cost.

Recognition Programs

Many agencies also have their own recognition programs, which are an important part of total rewards.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is one of your many benefits as an employee of the State of Arizona. Please use this benefit as needed. EAP is available to assist you in achieving and maintaining your highest level of job performance. EAP provides you with the opportunity to resolve a wide range of personal and job-related issues. If you need assistance in addition to your usual coping skills to deal with personal or job related issues, EAP may be the answer. Visit the EAP website at *www.benefitoptions.az.gov/ EAP.*

Arizona Government University (AzGU)

Arizona Government University (AzGU) is the 24/7 learning connection for employees of the State and other government agencies. AzGU is committed to meeting the ever-changing operational, strategic and individual learning needs within state government through multiple learning channels, quality programs and exceptional customer service. AzGU offers a wide range of courses from mandated core courses such as Standards of Conduct to leadership development to computer software programs, in a variety of formats: classroom, lab, web conferencing and narrative self-study. Employees can earn college credit through completion of the 40-hour Supervisor Academy.

In addition, AzGU maintains the training records for all state employees. Log onto *www.azgu.gov* to see what Arizona Government University has to offer you!

Children’s Day Care Center

State employees who have children or grandchildren are eligible to enroll those dependents in the Child Care Development Center. The center is operated by LaPetite Academy and is accredited and licensed.

The facility is located at 1937 W. Jefferson Street, Phoenix, Arizona. The cost for enrollment varies by the age of the child. For more information or for a tour of the facility, contact the Child Care Development Center’s Director at 602.542.1937.

457 Deferred Compensation Plan

Nationwide Retirement Solutions provides public employees their 457 deferred compensation plan. The plan allows state employees to invest pre-tax dollars into a supplemental retirement account. The state oversees the administration of the plan while NRS provides enrollment, plan administration and retirement education.

Maximum Deferral: $15,500.00, or 100% of Includible Compensation, for 2009, unless eligible for catch-up provisions, in which case you might be able to defer more.

Minimum Deferral:$10.00 per pay period, $20.00 per month
The amount you choose to contribute will depend on your specific situation. There is no “one-size-fits-all” solution. Your strategy will likely involve contributing as much as you can on a regular basis. The strategy you choose will depend on many variables, including the amounts you might receive from your pension and Social Security, what your investments earn between now and the time you retire, and what kind of standard of living you want at retirement. Regardless of how much you can afford to contribute, there are benefits to joining the deferred compensation program sooner rather than later.

Please contact a local representative at 602.266.2733 (or toll free at 1.800.796.9753) to schedule a consultation or for a list of scheduled educational seminars. You may also visit the local office at 4747 N. 7th Street, Suite 418, Phoenix, Arizona (office hours: 8 a.m. to 5 p.m.).

Arizona State Savings and Credit Union

You may also take advantage of the services provided by the Arizona State Savings and Credit Union.

Paid Time Off

As part of your compensation as a State employee, you receive paid time off. For detailed information regarding paid time off, review the State of Arizona Personnel Rules, Article 4. Also, be sure to familiarize yourself with your agency's policies and procedures for requesting the various types of leave.

State Service Holidays (10 days)

- January 1, New Year's Day
- 3rd Monday in January, Martin Luther King, Jr./Civil Rights Day
- 3rd Monday in February, Lincoln/Washington/Presidents' Day
- Last Monday in May, Memorial Day
- July 4, Independence Day
- 1st Monday in September, Labor Day
- 2nd Monday in October, Columbus Day
- November 11, Veterans' Day
- 4th Thursday in November, Thanksgiving Day
- December 25, Christmas Day

**If the holiday falls on Saturday, then it is observed on the preceding Friday. If the holiday falls on Sunday, then it is observed on the following Monday.

Annual Leave

Eligible employees accrue annual leave in accordance with the following schedule:

Credited Service	Hours Accrued Biweekly
Less than 3 years	3.7
3 years but less than 7 years	4.62
7 years but less than 15 years	5.54
15 or more years	6.47

Eligible part-time employees accrue a proportional amount of annual leave. Accumulation during a calendar year is unlimited; however, annual leave accumulated in excess of 240 hours at the end of a calendar year is subject to forfeiture, unless the ADOA Director authorizes an exception in an individual case.

Sick Leave

Eligible employees accrue sick leave at the rate of eight hours per month. Eligible part-time employees accrue a proportional amount of sick leave. Accumulation is unlimited.

Employees who retire with 500 or more unused sick leave hours may file for accumulated sick leave benefits through their personnel office.

Miscellaneous Paid Leave

- Civic Duty Leave
- Military Leave
- Educational Leave
- Bereavement Leave

Be sure to follow the personnel rules and your agency's guidelines if the need should arise for these leave categories.

Parental Leave

Parental leave is any combination of annual leave, sick leave, compensatory leave, or leave without pay (LWOP) taken by an employee due to pregnancy, childbirth, miscarriage, abortion or adoption of children.

Leave Without Pay (LWOP)

LWOP is defined as a leave which has been approved in advance, in writing, for a period of time, when there will be no paycheck from the employer.

The State’s Personnel Rules explain the procedures and conditions for LWOP including authorization, use, documentation, return to work, and benefits.

If in the future you are on LWOP, be sure you and your benefits liaison fully discuss your benefit options, costs, and the effect your decisions will have on your benefits upon your return to work. When your LWOP begins, you can make changes to your coverage, such as switching from family to single coverage, lowering the amount of supplemental life or declining some or all coverage.

Generally, an employee who is on LWOP must pay both the employee and employer portion to maintain medical and dental health care coverage and basic life insurance. Vision, supplemental life insurance and disability coverage have only employee-paid premiums. The only exceptions are LWOP due to industrial disability or leave covered by the Family and Medical Leave Act (FMLA). Employees on industrial or FMLA leave may continue benefits by paying just the employee portion for periods of time established by applicable laws and rules. If the employee is on leave beyond these limits, the employee must pay both the employer and employee portions of premiums to continue coverage.

If the employee on LWOP allows premium payment to become delinquent, coverage terminates. If the employee’s coverage was cancelled for non-payment, the employee cannot re-enroll until the first open enrollment after the employee returns to work. If the employee’s coverage was not cancelled for non-payment of premium, the employee can restore the coverage changed at the start of the leave upon his or her return to active employment.

An employee who chooses to go on LWOP has many decisions to make and should fully discuss them with his or her benefits liaison. Employees returning from LWOP should check their payroll deductions for any discrepancies with the coverage choices made.

Agency-Specific Benefits

Your agency may provide other benefits, such as an agency newsletter, employee assistance programs, award programs and/or recognition leave. For information ask your agency's Human Resources/Personnel office.

When You Leave State Service

Termination

If you should terminate employment with the State of Arizona, most likely you will have insurance continuation rights, for certain coverage, under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The former employee who elects this continuation of coverage pays 102% of the full monthly premium (employee cost + employer cost + 2% administrative fee).

Retirement

When you retire from State service, you have the option of continuing medical, dental and/or vision coverage through the ADOA Benefit Options Program or electing coverage through the program sponsored by your retirement system. Retirees pay the entire monthly premium; however, if you qualify, your retirement system may subsidize your monthly medical and/or dental premium in an amount relative to your length of service. Many retirees who have Medicare A and B can choose a Medicare Contract HMO, and the State subsidy may cover the entire medical and dental plan premium. Retirees may also elect COBRA coverage.

Retires who choose COBRA coverage or retirement system coverage may not later return to the plan sponsored by ADOA. However, those retirees who elect COBRA coverage may elect coverage through their retirement system when their COBRA coverage terminates.

Glossary of Terms

Actively at Work

Employees are considered actively at work on an employer's scheduled workday if they are performing in the usual manner all of the regular duties of their work on a full-time basis on that day, whether at their usual place of work or at another place if required to travel. Employees are also considered actively at work either on a paid vacation day or on a day that is not one of the employer's scheduled workdays only if they were actively at work on the preceding scheduled workday. Additional criteria may apply for specific coverage's.

Coinsurance

The division of the allowed amount to be paid by the insurance and the patient, i.e., 50/50, 70/30, or 80/20 after the deductible is satisfied.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

This act requires that continuation of group insurance coverage be offered to enrolled persons who lose health or dental coverage due to a qualifying life event as defined in the act.

Coordination of Benefits

A process used to eliminate duplication of benefits when a person is covered under more than one group plan. Benefits under the two plans are limited to no more than 100 percent of the claim.

Co-payment

The fixed fees that must be paid to the provider at the time services are provided, such as the pharmacist for a prescription.

Deductible

The initial amount the patient must pay out-of-pocket for covered services before benefits are payable by insurance.

Emergency

Defined by each plan in accordance with the standard definition.

Eligible Employee

State employee regularly scheduled to work 20 hours or more per week.

Enrollee

A person (employee, COBRA participant or dependent) who has met the eligibility requirements and is enrolled in an insurance plan.

EPO (Exclusive Provider Organization)

An EPO (Exclusive Provider Organization) is a managed care plan which requires members to use providers who are contracted with that health plan. The member must pay any co-pays as indicated. If a member enrolled in an EPO and uses a provider who is not contracted with the plan, the member will be personally liable for his/her bill.

Full-time Student

A qualified Full-time student is an unmarried child who is 19 years of age but less than 25 years of age who is enrolled in and attending a high school or a post-secondary accredited institution of learning on a full-time basis as defined by the institution.

Incurred Expense

An expense is considered incurred on the date services were rendered or supplies were received.

Identification Number

Number issued by the employer and/or insurance provider for utilization of services.

Plan Year

October 1 through September 30.

PPO (Preferred Provider Organization)

Allows in-network and out-of-network treatment. If you obtain out-of-network treatment, you will need to meet a deductible and will pay a percentage of all covered services.

Premium

The amount a covered person and/or employer pays in exchange for insurance coverage.

Self-Insured Plan

A self-insured plan is one in which the employer or group of employers assumes the direct financial responsibility for the costs of enrollees' health insurance claims. Employers sponsoring self-insured plans typically contract with an insurance carrier or third party administrator to provide administrative services for the self-insured plan.

Privacy Practices

The administrators of Arizona Benefit Options know that the privacy of your personal information is important to you. This notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Throughout this notice, all references to Arizona Benefit Options refer to the administrators of the program. Please review it carefully.

Use and Disclosure of Health Information

Arizona Benefit Options may use your health information for purposes of making or obtaining payment for your care, and for conducting health care operations. Arizona Benefit Options has established a policy to guard against unnecessary disclosure of your health information. For purposes of this Notice, health information refers to any information that is considered protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act (”HIPAA”) of 1996.

The Following is a Summary of the Circumstances Under Which and Purposes for Which Your Health Information May Be Used and Disclosed

To Make or Obtain Payment

Arizona Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Arizona Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations

Arizona Benefit Options may use or disclose health information for its own operations to facilitate the administration of Arizona Benefit Options and as necessary to provide coverage and services to all Arizona Benefit Options’ participants. Health care operations include activities such as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Reviews and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection with the solicitation of health plans or the modification or amendment of the existing plan.

As an example, Arizona Benefit Options may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives Arizona Benefit Options may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services Arizona Benefit Options may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

When Legally Required, Arizona Benefit Options will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities Arizona Benefit Options may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Arizona Benefit Options, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings As permitted or required by state law, Arizona Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Arizona Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes As permitted or required by state law, Arizona Benefit Options may disclose your health information to a law enforcement official for certain law enforcement purposes, including but not limited to if Arizona Benefit Options has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In The Event of a Serious Threat to Health or Safety Arizona Benefit Options may, consistent with applicable law and ethical standards of conduct, disclose your health information if Arizona Benefit Options, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

For Specified Government Functions In certain circumstances, federal regulations require Arizona Benefit Options to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For Workers Compensation Arizona Benefit Options may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

Authorization to Use or Disclose Health Information
Other than stated above, Arizona Benefit Options will not disclose your health information without your written authorization. If you authorize Arizona Benefit Options to use or disclose your health information, you may revoke that authorization in writing at any time.

Rights with Respect to Your Health Information
You have the following rights regarding your health information that Arizona Benefit Options maintains:

Right to Request Restrictions You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Arizona Benefit Options' disclosure of your health information to someone involved in the payment of your care. However, Arizona Benefit Options is not required to agree to your request.

Right to Receive Confidential Communications To safeguard the confidentiality of your health information, you may request that Arizona Benefit Options communicate in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Arizona Benefit Options will accommodate reasonable requests, when possible.

Right to Inspect and Copy Your Health Information You have the right to inspect and copy your health information. If you request a copy of your health information, Arizona Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information If you believe that your health information records are inaccurate or incomplete, you may request that Arizona Benefit Options amend the records. That request may be made as long as the information is maintained by Arizona Benefit Options. Arizona Benefit Options may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Arizona Benefit Options, if the health information you are requesting to amend is not part of Arizona Benefit Options' records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if Arizona Benefit Options determines the records containing your health information are accurate and complete.

Right to an Accounting You have the right to request a list of disclosures of your health information made by Arizona Benefit Options for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Arizona Benefit Options will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Arizona Benefit Options will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

Duties of Arizona Benefit Options

Arizona Benefit Options is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Arizona Benefit Options is required to abide by the terms of this Notice, which may be amended from time to time. Arizona Benefit Options reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Arizona Benefit Options changes its policies and procedures, Arizona Benefit Options will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Arizona Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Arizona Benefit Options encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

For more information or for further explanation of this document, you may contact an Arizona Benefit Options representative at 602.542.5008 (outside the Phoenix area, toll free at 1.800.304.3687), or by email at beneissues@azdoa.gov. You may also obtain a copy of this Notice at our web site at *www.benefitoptions.az.gov.*

Effective Date

This Notice is effective April 14, 2003.